VALUEOPTIONS Inpatient Treatment Report (ITR) - Page One of Two

Requested Start Date for this Authorization: ____/____/____

Level of Care: ❑ Inpatient ❑ 23hr ❑ CSU ❑ Partial ❑ RTC ❑ IOP/SOP
❑ Group Home ❑ Halfway House ❑ Other: _____

Tx Unit/Program: _____
Type of Review: ❑ Prospective ❑ Concurrent ❑ Discharge ❑ Retrospective
Type of Care: ❑ Mental Health ❑ Substance Abuse ❑ Detox
Precipitating Event: _____

_____

Member's Current Location: ❑ ER ❑ Jail/Detention ❑ Facility
❑ Provider's Office ❑ Home/Community

Demographics:

Member's Name: _____ Date of Birth: _____
Member/Policyholder ID #: _____ Tel #: _____
Member's City/State: _____
Insured's Employer/Benefit Plan: _____
Facility: _____ Fac. ID #: _____
Fac. Address/City/St.: _____
Attending Provider: _____
Attending's Phone #: _____
UR Name: _____
UR Phone #: _____ UR Fax #: _____

DSM-IV Diagnosis:

Axis I: 1) _____ 2) _____
Axis II: 1) _____ 2) _____
Axis III: 1) _____ 2) _____
Axis IV: 1) _____
Axis V: Current GAF: _____ Highest GAF prev. year: _____

Current Risks: *Risk Level Scale: 0=none, 1=mild, ideation only; 2=moderate, ideation with EITHER plan or history of attempts; 3=severe, ideation AND plan, with either intent or means; na = not assessed. Circle risk level for each category, and check all boxes that apply:*

Risk to Self (SI): 0 1 2 3 na with ❑ ideation ❑ intent ❑ plan ❑ means
Risk to Others (HI): 0 1 2 3 na with ❑ ideation ❑ intent ❑ plan ❑ means
Current serious attempts: ❑Yes ❑ No *Circle*: SI HI
Prior serious attempts: ❑Yes ❑ No *Circle*: SI HI
Prior serious gestures: ❑Yes ❑ No *Circle*: SI HI
Date of the most recent attempt or gesture: ____/____/____

Current Impairments: *Scale: 0=none, 1=mild, 2=moderate, 3=severe, na = not assessed.*

0 1 2 3 na Mood Disturbance (Depression or mania)
0 1 2 3 na Anxiety
0 1 2 3 na Psychosis
0 1 2 3 na Thinking/Cognition/Memory
0 1 2 3 na Impulsive/Reckless/Aggressive
0 1 2 3 na Activities of Daily Living
0 1 2 3 na Weight Loss Assoc. with Eating D/O⇨ ❑Gain ❑Loss ❑na of _____ pounds in last three months.
0 1 2 3 na Medical/Physical Condition(s) Current weight = _____ lbs. ❑na
0 1 2 3 na Substance Abuse/Dependence Height = _____ ft. _____ in. ❑na
0 1 2 3 na Job/School Performance
0 1 2 3 na Social/Marital/Family Problems
0 1 2 3 na Legal

Mental Health/Psychiatric Treatment History: *(Please check all that apply)* ❑ None ❑ Unknown

❑ Outpatient. *If "Outpatient" is checked, please indicate:*
Outcome: ❑ Unknown ❑ Improved ❑ No change ❑ Worse
Treatment compliance (non-med): ❑ Unknown ❑ Poor ❑ Fair ❑ Good

❑ IOP/Partial. *If "IOP/Partial" is checked, please indicate:*
Outcome: ❑ Unknown ❑ Improved ❑ No change ❑ Worse
Treatment compliance (non-med): ❑ Unknown ❑ Poor ❑ Fair ❑ Good

❑ Inpatient/Residential/Group Home. *If "Inpatient/Residential" is checked, please indicate:*
Outcome: ❑ Unknown ❑ Improved ❑ No change ❑ Worse
Treatment compliance (non-med): ❑ Unknown ❑ Poor ❑ Fair ❑ Good
Number of psychiatric hospitalizations in the past 12 months: _____
Number of psychiatric hospitalizations in lifetime: _____

Substance Abuse Treatment History: *(Please check all that apply)* ❑ None ❑ Unknown

❑ Outpatient. *If "Outpatient" is checked, please indicate:*
Outcome: ❑ Unknown ❑ Improved ❑ No change ❑ Worse
Treatment compliance (non-med): ❑ Unknown ❑ Poor ❑ Fair ❑ Good

❑ IOP/Partial. *If "IOP/Partial" is checked, please indicate:*
Outcome: ❑ Unknown ❑ Improved ❑ No change ❑ Worse
Treatment compliance (non-med): ❑ Unknown ❑ Poor ❑ Fair ❑ Good

❑ Inpatient/Residential. *If "Inpatient/Residential" is checked, please indicate:*
Outcome: ❑ Unknown ❑ Improved ❑ No change ❑ Worse
Treatment compliance (non-med): ❑ Unknown ❑ Poor ❑ Fair ❑ Good
Number of substance abuse hospitalizations in the past 12 months: _____
Number of substance abuse hospitalizations in lifetime: _____

Other Treatment History: *(Please check all that apply)*

Mandatory workplace referral? ❑ Yes ❑ No EAP involved? ❑ Yes ❑ No
EAP Name: _____
Is member currently receiving disability benefits? ❑ Yes ❑ No
Current psychotropic meds? ❑ Yes ❑ No *If yes, please complete below.*

Current Psychotropic Medications:	*Dose*	*Frequency*	*Usually adherent?*
			❑Yes ❑No
			❑Yes ❑No
			❑Yes ❑No
			❑Yes ❑No

Substance Use/Abuse: ❑ No ❑ Yes ❑ Unknown *If yes, please complete below.*

Substance	*Total Yrs. Use*	*Length Curr. Use*	*Amount*	*Frequency*

Withdrawal Symptoms: *Check all that apply.* ❑ None

❑ Nausea ❑ Sweating ❑ Tremors ❑ Past DTs
❑ Vomiting ❑ Agitation ❑ Blackouts ❑ Current Seizures
❑ Cramping ❑ Hallucinations ❑ Current DTs ❑ Past Seizures

Vitals *(if Detox or Relevant)*: BP: ____Temp: _____ Pulse: ____ Resp: _____ BAL: _____
UDS: ❑ Yes ❑ No Outcome: ❑ Pending ❑ Negative ❑ Positive
If positive, for what? _____ CIWA: _____
Longest period of sobriety: ❑< 6 mo. ❑ 6 mo.-2 yrs ❑ 2+ yrs ❑None ❑Unknown
Relapse Date: ____/____/____

ASAM Dimensions:

1: Intoxicated/WD Potential ❑Lo❑Med❑Hi 4: Readiness to Change ❑Lo❑Med❑Hi
2: Biomedical Conditions ❑Lo❑Med❑Hi 5: Relapse Potential ❑Lo❑Med❑Hi
3: Emot/Beh/Cog Condtns ❑Lo❑Med❑Hi 6: Recovery Environment ❑Lo❑Med❑Hi

Treatment Request: **Admit Date: ____/____/____**

(Note well: Each level of care, ECT &/or Psych Testing requires separate precertification.)

Is family/couples therapy indicated? ❑ Yes ❑ No If yes, date of appt:____/____/____
❑ Involuntary ❑ Court Ordered ❑ Fixed Length Program (*specify length:* _____)
Frequency of program = _____ per _____
Reason for Continued Stay: ❑ Remains symptomatic ❑ Conduct family therapy
❑ Stabilize medications ❑ Has not achieved treatment goals ❑ Finalize dischg. plan
❑ Other: _____
Barriers to Discharge: ❑ Discharge treatment setting not available ❑ Transportation
❑ Legal Mandate ❑ Adequate Housing/Residence ❑ Lack of Community Supports
❑ Treatment Non-Compliance
❑ Other: _____
Baseline Functioning: ❑ Holds Job ❑ Asymptomatic ❑ Manages Meds/Med Compliant
❑ Functions Independently/ADLs Satisfactory ❑ Abstinent
❑ Other: _____

Discharge Plan:

Expected D/C Date if known:____/____/____ Estimated return to work date:____/____/____
Planned D/C Level of Care: ❑ Outpatient ❑ Inpatient ❑ 23 hr ❑ CSU ❑ RTC ❑ Partial
❑ IOP/SOP ❑ Group Home ❑ Halfway House ❑ Other: _____
Planned D/C Residence: ❑ Home (❑ Alone or ❑ w/Others)
❑ Nursing Home/SNF/Asst. Living ❑ RTC/Group Home/Halfway House ❑ Shelter
❑ Correctional Facility ❑ Foster Care ❑ Respite ❑ State Hosp. ❑ Residential Placemt.
❑ Juvenile Detention ❑ Transfer to Medical ❑ Transfer to Alternate Psych. Facility
❑ Other: _____

By completing this box, you will assure this page is linked to the first page, should they become separated. Thank you.

Member's Name: _____
Member's ID# _____ Member DOB: _____

Discharge Information: *(to be included upon discharge)*

Actual Discharge Date: ____/____/____
Primary Discharge Diagnosis: _____
Discharge GAF: _____
Discharge Condition: ❑ Improved ❑ No change ❑ Worse

Treatment involved the following *(check all that apply)*: ❑ Adverse Incident
❑ Child Protection ❑ EAP ❑ Family ❑ Legal System ❑ OP Provider
❑ Other Support Systems ❑ PCP ❑ None ❑ Other: _____
Note: any adverse incidents must be reported immediately to ValueOptions
Total # Days/Sessions Used: _____ Discharge plans in place? ❑ Yes ❑ No
Type of discharge: ❑ Planned or ❑ AMA PCP Notified?: ❑ Yes ❑ No

Actual Discharge Level of Care: ❑ Outpatient ❑ Inpatient ❑ 23 hr ❑ CSU
❑ RTC ❑ Partial ❑ IOP/SOP ❑ Group Home ❑ Halfway House
❑ Other: _____
Actual Discharge Residence: ❑ Home (❑ Alone or ❑ w/Others)
❑ Nursing Home/SNF/Asst. Living ❑ RTC/Group Home/Halfway House
❑ Shelter ❑ Corrrectional Facility ❑ Foster Care ❑ Respite
❑ State Hospital ❑ Residential Placement ❑ Juvenile Detention
❑ Transfer to Medical ❑ Transfer to Alternate Psych. Facility
❑ Other: _____

Member/Family Member Name for Follow Up:

_____
Relationship: _____
Phone #: _____ ❑Do not know
AfterCare Behavioral Health Provider: ❑Not arranged ❑Do not know
AfterCare Provider Name: _____
AfterCare Prov. Tel. #: _____
Scheduled Appointment Date: ____/____/____
Type of Appointment: ❑ Mental Health ❑ Substance Abuse ❑ Med. Mgmt.

Prescribing Physician: ❑ Not arranged ❑ Do not know
Prescribing Physician Name: _____
Prescribing Physician Tel #: _____
Prescriber: ❑ PCP ❑ Psychiatrist ❑ Other Prescriber Type
Scheduled Appointment Date: ____/____/____

_____
Signature of Person Completing This Form Date